

SERFF Tracking Number:	BANN-127145394	State:	Arkansas
Filing Company:	Banner Life Insurance Company	State Tracking Number:	48639
Company Tracking Number:			
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Additional Insurance Rider		
Project Name/Number:	Additional Insurance Rider/AIR (1-11)		

Filing at a Glance

Company: Banner Life Insurance Company

Product Name: Additional Insurance Rider

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: BANN-127145394 State: Arkansas

SERFF Status: Closed-Approved-
Closed

Co Tr Num:

Author: Ada Miller

Date Submitted: 05/02/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 05/05/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: 05/16/2011

State Filing Description:

General Information

Project Name: Additional Insurance Rider

Project Number: AIR (1-11)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/27/2011

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 05/05/2011

State Status Changed: 05/05/2011

Created By: Ada Miller

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Ada Miller

Filing Description:

The above-referenced form is being submitted for your review and approval. Upon approval, AIR (1-11), if elected, will be attached to our term life products. The term product, RT-97, was approved by your department on 10/22/97 and 11/20/97 for the different term levels. Our Value Term product was approved by you on 11/18/09 using policy schedule pages RT-97 IPT2 and RT-97 IPT3.

Implementation date for this rider is May 16, 2011.

The Additional Insurance Rider provides for additional life insurance on the insured for a limited time period of either 10, 15, or 20 years. Premiums are level for these time periods and are fully guaranteed. The rider will be available for issue ages 20-60 for 10 year term, 20-55 for 15 year term, and 20-50 for 20 year term. An Actuarial Memorandum and

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Certification are included. A sample of policy schedule page 3 is also attached and will be used if this rider is elected.

To the best of our knowledge, information, and belief, this form complies with the rules and regulations of your department.

Company and Contact

Filing Contact Information

Ada Miller, Compliance Technician amiller@lgamerica.com
 1701 Research Boulevard 301-279-4809 [Phone]
 Rockville, MD 20850 301-294-6964 [FAX]

Filing Company Information

Banner Life Insurance Company CoCode: 94250 State of Domicile: Maryland
 1701 Research Boulevard Group Code: 872 Company Type: Life Insurance
 Rockville, MD 20850 Group Name: State ID Number:
 (301) 279-4809 ext. [Phone] FEIN Number: 52-1236145

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 1 form x \$50
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Banner Life Insurance Company	\$50.00	05/02/2011	47130309

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/05/2011	05/05/2011

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Disposition

Disposition Date: 05/05/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Sample Policy Schedule		Yes
Form	Additional Insurance Rider		Yes

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Form Schedule

Lead Form Number: AIR (1-11)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	AIR (1-11)	Policy/Cont ract/Fratern al Certificate	Initial		68.275	AIR (1-11).pdf

Additional Insurance Rider

General

In this Benefit Rider, Banner Life Insurance Company will be referred to as “we”, “our” or “us” or “company”. The “policy” is the policy to which this rider is attached. Coverage pursuant to this rider will be effective on the Policy Date shown in the policy schedule. This rider is subject to all terms and conditions of the policy, except as provided in this rider. For purposes of this rider, the insured is as defined in the policy.

Rider Benefit

We will pay the beneficiary an Additional Insurance Amount, in addition to any death benefit payable under the policy, when we receive due proof that the insured’s death occurred while this rider was in force. The Additional Insurance Amount is as shown in the policy schedule.

Payment will be made in accordance with the terms of the policy. This rider does not have cash values or loan values.

Attained Age

Attained age means the insured’s age as of the nearest birthday on the last policy anniversary.

Rider Premium

The premiums for this rider are shown in the policy schedule pages.

Incontestability

We cannot contest this rider, except for nonpayment of premium or fraud (where permitted by applicable law in the state where the policy is delivered), after it has been in force during the lifetime of the insured, for two years after the policy Issue Date. However, if this rider has been reinstated, it will be incontestable, except for nonpayment of premium or fraud (where permitted by applicable law in the state where the policy is delivered), only after it has been in force during the lifetime of the insured for two years after the effective date of the reinstatement. If the rider has been reinstated after two years from the policy Issue Date, only statements in the reinstatement application may be used to contest the rider. If reinstatement occurs within two years of the policy Issue Date we may:

1. contest statements on the original application for two years after the policy Issue Date; and
2. contest statements on the reinstatement application for two years after the effective date of reinstatement.

Waiver of Premium Benefit

If the policy to which this rider is attached has waiver of premium coverage, such coverage will apply to this rider as well. Premiums for the waiver benefit applies to this rider are shown in the policy schedule.

Conversion

This rider may be converted to a new policy on the insured’s life. Evidence of the insured’s insurability is not required. The conversion may be made:

1. on any premium due date, but not later than the end of the Additional Insurance conversion period shown in the policy schedule;
2. if we receive the owner’s written request and application for conversion;
3. if the first premium for the new policy is paid.

The new policy will be issued:

1. with the date of exchange as its policy date;
2. at the insured’s age nearest birthday on the date of exchange;
3. with the same rating classification as that under the rider;
4. on any permanent life plan for the amount exchanged, which we have available for conversion and which we customarily issue on the date of exchange to applicants with the insured’s rating classification

5. with premiums based on our rates for the rating classification and plan of insurance on the date of exchange;
6. for an amount of insurance not less than our minimum for the plan selected, nor greater than the Additional Insurance Amount of this rider on the exchange date. At least one plan of insurance will be available for conversion in an amount equal to the death benefit of this rider on the exchange date;
7. the new policy incontestability and suicide provisions attributable to the coverage converted will run from the policy Issue Date. If the new policy includes additional coverage for which evidence of insurability is given, new incontestability and suicide provisions may apply to that coverage;
8. the new policy will be subject to any assignment of the policy received at our home office.

The new policy will contain a waiver of premium benefit if:

1. This rider is covered under a waiver of premium benefit on the exchange date;
2. on the date of exchange, we customarily issue such benefit to applicants with the insured's age, sex, and rating classification; and
3. on the date of exchange, we customarily issue such benefit in conjunction with the plan to which the insured converts.

If more than one type of waiver of premium benefit is available on the date of exchange, the benefit attached to the new policy will be the benefit with the lowest premium.

Automatic conversion

This rider will be converted to a permanent life insurance plan selected by us at the end of the conversion period if:

1. at the end of the Additional Insurance conversion period, this rider was covered under a waiver of premium benefit and the insured is totally disabled under the terms of such benefit;
2. such total disability continued for more than 6 months prior to the end of the additional insurance conversion period.

The new policy's premiums will be based on the insured's age on the date this rider is converted. The new policy will be issued for an amount equal to the Additional Insurance Amount for this rider on the exchange date. Any premium falling due while the insured continues to be totally disabled will be waived.

Suicide

If the insured dies by suicide within two years after policy Issue Date, the death benefits payable will be limited. In such case, our liability will be limited to a refund of all rider premiums paid.

Termination

This rider will terminate:

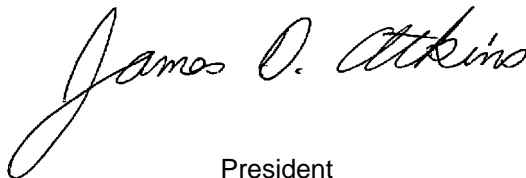
1. upon maturity, surrender, termination, or conversion of the policy; or
2. at the Additional Insurance Expiration Date, as shown on the policy schedule; or
3. upon nonpayment of the required premium, in accordance with the provisions of the policy; or
4. if this rider is converted, as set forth in the conversion privilege; or
5. upon written request by the owner.

This rider is subject to the conditions of the policy. Where a conflict between the rider and the policy exists, the conditions of the rider will control.

Signed for us at our home office in Rockville, Maryland.



Secretary



President

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Flesch Certification is attached. Attachment: Flesch Readability Certification AIR (1-11).pdf		
Satisfied - Item: Application Comments: Previously approved life app on 10/17/08 is attached. Attachments: LIA (10-08).pdf LU-1267 (10-08).pdf		
Satisfied - Item: Sample Policy Schedule Comments: Sample policy schedule attached Attachment: RT97 AIRSP PSP.pdf		

Readability Certification
AIR (1-11) Additional Insurance Rider

This is to certify that the form in this filing has been tested and meets the minimum required Flesch reading ease score.

Additional Insurance Rider, Form AIR (1-11), yielded a score of 68.275.

It is not in less than 10-point type, one-point leaded.

The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text of the policy or to any endorsements or riders



Nancy C. January, FSA, MAAA
Vice President, Product Development
Banner Life Insurance Company

February 18, 2011

Date

Internet address: www.bannerlife.com**INSTRUCTIONS**

As the Agent, you are responsible for completing the necessary forms required to process and underwrite this application. All forms must be completed in full and must be legible. Please follow these instructions carefully.

DO

- Print application in black ink.
- Verify identification of Proposed Insured.
- Obtain all of the necessary signatures.
- Give the Notice to Proposed Insured to your client.
- Have the Proposed Insured/Owner initial all changes. The Proposed Insured must initial all changes to questions involving insurability. Change an answer by putting a line through the incorrect answer and inserting the correct information.
- Complete Part 2, Medical History, if the Proposed Insured is to be considered without paramedical exam, if an exam on another company's form is being used or if an abbreviated exam will be done.
- Complete section K, Part 1 on all business cases and if required on non-business cases.
- Complete and obtain signature on Consent for HIV Testing Form for each Proposed Insured, if required in your state.
- If you accept payment with the application:
 - Complete the Temporary Insurance Application section of the Temporary Insurance Application and Agreement (TIAA), making sure that all questions are answered. If any are answered Yes, do not accept money.
 - Remit an amount equal to the first modal premium.
 - Explain the terms and conditions of the TIAA to the Owner and Proposed Insured and have them sign it.
 - Complete and sign the Licensed Insurance Agent's Statement on the TIAA.
 - Send the TIAA with the application, give the Owner a copy.
 - All checks collected must be made payable to Banner Life Insurance Company.
- If applicable, complete and obtain signature(s) on the Payment Options form.
- Complete and sign the Agent's Report on page 12. Please be sure to enter all agent information and your Banner agent number.

DO NOT

- Do not accept money on applications now applied for or pending with Banner Life Insurance Company totaling over \$1,000,000.
- Do not accept any payment if any question on the Temporary Insurance Application and Agreement is answered Yes or left blank.
- Do not accept cash or cash equivalents (money order, cashiers check) or "starter" checks.
- Do not accept money if the Proposed Insured is over age nearest 70.
- Do not use pencil or correction fluid.

Thank you for applying to Banner Life Insurance Company. The soliciting insurance broker (broker) should be able to answer any questions you may have. This broker is an independent broker, not an employee of Banner Life Insurance Company, and is not authorized to make or modify contracts or to waive any requirements or any information that we may request.

Underwriting

Once we receive your application, we will begin an evaluation process called underwriting to determine whether you are eligible for insurance and, if so, the rate you should pay for that insurance. We may find that we are unable to give you the insurance you have applied for or that we are able to give it to you only on a modified basis or at a rate greater than our lowest rate.

Your application will be our primary source of information; therefore, it must be true, complete, and accurate. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application. We may seek information from other sources to help us evaluate the information you give us on your application.

Contestability

We strongly urge you to review the completed application closely for accuracy. A claim may be denied, the policy may be void or your coverage may be lost if the application is incomplete or if it contains false statements or material misrepresentations. Any policy that may be issued will indicate when and under what circumstances it may be contested. Please be aware that if the application contains material misrepresentations or conceals material facts, and you submitted it with the intent to defraud or to facilitate fraud against us, you may also be guilty of insurance fraud, which is a crime. You must inform us of a change to any answer in any part of your application before accepting delivery of a policy; in fact, you agree to do so when you sign your application.

Replacement of Existing Coverage

If you intend to replace existing coverage, tell the broker of your intention and answer "yes" to the replacement question in the application; state law may require the broker to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain new suicide and contestable periods. The following would be considered replacement: you stop paying premiums on an existing policy or surrender an existing policy before or shortly after applying to us or you borrow from an existing policy to pay premiums for the insurance for which you are applying. State law may define replacement to include other situations. Ask the broker if you are unsure.

Insurance Information Practices

We will rely primarily on information provided by you. We may supplement that information with information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under Federal Fair Credit Reporting Notice. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about, and receive copies if you wish, of items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, MD 20850-3191.

Federal Fair Credit Reporting Notice

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

NOTICE TO PROPOSED INSURED**(Please give to the Proposed Insured)****(continued)**

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. Banner Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Banner Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

SECTION A PROPOSED INSURED

1. Full Name (Include maiden name in parentheses)		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth Month Day Year	4. Social Security Number
5. a. Home Address Street _____ City, State _____ Zip _____				5. b. How Long
6. Phone Numbers Home () Work ()	7. State/Country of Birth	8. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No Visa Type _____ If No, Date of Entry into U.S. _____ Country of Citizenship _____		
9. Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	10. Driver's License Number and State of Issue or State ID Number			
11. Occupation (Include duties)		12. Annual Income	13. Total Net Worth	
14. a. Employer's Name and Address and Nature of Business				14. b. How Long Employed
15. Have you ever used tobacco or nicotine products in any form? <input type="checkbox"/> Yes - give details below <input type="checkbox"/> No				
Product	Date last used (month/year)	Amount / Frequency		
Cigarettes				
Cigars				
Other				

SECTION B BENEFICIARY (Share percentage totals must equal 100%. If necessary, use Remarks section, Question 48. If Beneficiary is a trust, check box ☐ and complete Section D.)

16. Primary				
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____
17. Contingent				
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____
Name _____	Relationship _____	SSN _____	Date of Birth _____	% Share _____

SECTION C OWNER

18. Owner is <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Trust (also complete Section D) <input type="checkbox"/> Other than Proposed Insured or Trust				
Complete if the Proposed Insured is not the Owner. (If contingent Owner is required, use Remarks section, Question 48).				
Name _____	SSN or Tax ID # _____	Date of Birth _____		
Address _____	City, State _____	Zip _____		
Contact Phone # _____	Relationship to Proposed Insured _____			
If Owner is a business, web site address _____		Email address _____		

SECTION D TRUST INFORMATION (If trust is Beneficiary and/or Owner).

19. Exact Name of Trust _____	Trust Tax ID# _____
Current Trustee(s) _____	Date of Trust _____

PART 1 (continued)**SECTION E PAYOR**20. Send premium notices to: ☐ Insured ☐ Owner ☐ Other - If Other, complete the information below

Name _____ Relationship to Insured/Owners _____

Address _____
Street City State Zip

Contact Phone # _____ Email address _____

SECTION F INSURANCE APPLIED FOR

21. Amount of Insurance \$ _____ 22. Plan of Insurance _____

23. Death Benefit Option (if available with Plan): ☐ Level Death Benefit ☐ Increasing Death Benefit24. Payment method: ☐ Direct Bill ☐ Electronic Funds Transfer (EFT)25. Frequency of premium payment: ☐ Single ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (EFT only)

26. Planned periodic premium for universal life product: (Provide details in Remarks section, Question 48.)

a. ☐ 1st Year Only \$ _____ 2nd Year and Thereafter \$ _____ b. ☐ Premium For All Years \$ _____27. Will the premiums for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? ☐ Yes ☐ No

If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. (Provide details in Remarks section, Question 48.)

28. a. Date to Save Age? ☐ Yes ☐ No b. Specific Policy Date? ☐ Yes ☐ No Date _____**Additional Benefits (if available)**29. ☐ Waiver of Premium ☐ Other (description and amount) _____**SECTION G OTHER INSURANCE**30. a. **Excluding** this application, amount of insurance **currently pending** with other companies. If NONE state NONE. \$ _____

b. Of the above pending amount in 30.a., how much do you intend to accept? \$ _____

c. Provide information for each policy in force (except group insurance). (If necessary, use Remarks section, Question 48.)
If NONE state NONE.

Company	Policy Number	Face Amount	Business?		Issue Date	Replacing?		Beneficiary
			Yes	No		Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No
31. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount? (If Yes, provide details in Remarks section, Question 48.)	<input type="checkbox"/>	<input type="checkbox"/>

32. Will you, or are you likely to, replace, end, or change existing insurance or annuity with any company or society with the insurance for which you are applying? (If Yes, the broker may be required to provide additional forms for your review and signature.)	<input type="checkbox"/>	<input type="checkbox"/>
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33. Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor, or will it replace a policy that has already been sold to another life settlement company or investor? (If Yes, provide details in Remarks section, Question 48.)	<input type="checkbox"/>	<input type="checkbox"/>
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PART 1 (continued)

SECTION H GENERAL QUESTIONS (Explain all Yes answers in Remarks section, Question 48.)		Yes	No
34. Has any person promised or agreed to give or have they given to any party to the application, any inducement, fee or compensation as an incentive to purchase the policy?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Has any party to the application ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	<input type="checkbox"/>	<input type="checkbox"/>	
36. Has any party to the application ever received inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?	<input type="checkbox"/>	<input type="checkbox"/>	
37. In the past 5 years, have you requested or received a Worker's Compensation, Social Security, or disability income payment?	<input type="checkbox"/>	<input type="checkbox"/>	
38. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	<input type="checkbox"/>	<input type="checkbox"/>	
39. In the past 5 years, has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?	<input type="checkbox"/>	<input type="checkbox"/>	
40. In the past 5 years, have you been convicted of, or plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs? (If Yes, complete Alcohol/Drug Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
41. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION I OTHER ACTIVITIES		Yes	No
42. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? (If Yes, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
43. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving? (If Yes, complete appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	
44. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? (If Yes, list countries, cities, duration and purpose of travel in Remarks section, Question 48.)	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION J PROPOSED INSURED FINANCIAL INFORMATION	
Complete this section when applying for face amount over \$1,000,000 or when the Proposed Insured is over age 65:	
45. a. What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson, estate conservation)	_____
b. How was the need for the face amount determined? _____	_____
c. In the last 5 years, has the Proposed Insured filed for bankruptcy or had any charge off of bad debts?	<input type="checkbox"/>
If Yes, type of bankruptcy and discharge date or charge off date. _____	<input type="checkbox"/>
46. a. Gross annual earned income (salary, bonuses, etc. from W-2 forms)	\$ _____
b. Gross annual unearned income (dividends, interest, rental income, etc.)	\$ _____
c. Is the Proposed Insured self-supporting?	<input type="checkbox"/>
If No, how much insurance is in-force on the life of the person providing the support?	\$ _____
What is that person's relationship to the Proposed Insured? _____	_____

PART 1 (continued)**SECTION K BUSINESS FINANCIAL INFORMATION**

Complete this section when applying for face amount over \$1,000,000 and if Beneficiary or Owner is a business:

	Current YTD	Previous Year
47. a. Assets	\$	\$
b. Liabilities	\$	\$
c. Gross Sales	\$	\$
d. Net Income after Taxes	\$	\$
e. Fair Market Value of the business	\$	\$

f. How long has the business been established? _____

g. What percentage of the business does the Proposed Insured own? _____

h. Are other partners/owners/executives being insured? (If Yes, use Remarks section, Question 48.)

Yes No

☐ ☐

i. In the last 5 years, has the business filed for bankruptcy or had any charge off of bad debts?

☐ ☐

If Yes, type of bankruptcy and discharge date or charge off date. _____

j. Company web site address, if available _____

48. Remarks: Explanations and/or special requests. Use Part 1 Supplement to Application if necessary.

IN CONNECTION WITH THIS APPLICATION FOR INSURANCE, IT IS UNDERSTOOD AND AGREED THAT:

I/we have read the application and all statements and answers contained in Part 1 and Part 2 of this application and any supplements thereto, copies of which shall be attached to and made a part of any policy to be issued, are true and complete to the best of my/our knowledge and belief and made to induce Banner Life Insurance Company (the Company) to issue an insurance policy. The statements and answers in the application are the basis for any policy issued by the Company, and no information about me will be considered to have been given to the Company unless it is stated in the application. I agree to notify the Company of any changes to the statements and answers given in any part of the application before accepting delivery of any policy.

No agent or other person has power to: (a) accept risk; (b) make or modify contracts; (c) make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable; (d) waive any Company rights or requirements; (e) waive any information the Company requests; (f) discharge any contract of insurance; or (g) bind the Company by making promises respecting benefits upon any policy to be issued.

I agree that: **(1) I/we will notify the Insurer if any statement or answer given in any part of the application changes prior to policy delivery; and (2) except as provided in the Temporary Insurance Application and Agreement, if any, insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to and accepted by the Owner and the first modal premium is paid.**

Changes or corrections made by the Company and noted in Part 1, Question 48 above are ratified by the Owner upon acceptance of a contract containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information for me. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Company, Attn: Director of Underwriting, Banner Life Insurance Company, 1701 Research Boulevard, Rockville, Maryland 20850-3191.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed: ☐ Yes ☐ No

DECLARATION

I/we have carefully read the Temporary Insurance Application and Agreement (TIAA) and understand and agree to the terms thereof including the conditions under which a limited amount of insurance may become effective prior to policy delivery. I/we understand that all premium checks are to be made payable to **Banner Life Insurance Company** (payee should not be left blank); checks are not to be made payable to the agent, agency or other third party. I/we have received the Notice to Proposed Insured, which includes the Medical Information Bureau Pre-Notice Disclosure and the Federal Fair Credit Reporting Notice.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Please see fraud warnings on page 6 prior to signing this application.**

Signature of Proposed Insured Signed at _____ City/State on ____/____/____

Signature of Owner (if other than Proposed Insured) Signed at _____ City/State on ____/____/____
If Owner is a firm or corporation, include officers' title with signature

Print Owner/Officer Name and Title (if applicable)

Signature of Licensed Insurance Agent Signed at _____ City/State on ____/____/____

FRAUD WARNINGS

Arkansas, Kentucky, Louisiana, New Mexico, and Ohio

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information on an insurance application is guilty of a crime and may be subject to fines and imprisonment.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to a settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Georgia, Nebraska, South Carolina, Texas

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

Washington, D.C., Maine, Virginia, Tennessee, and Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Maryland

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey

Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

1. Name of Proposed Insured _____ Date of Birth _____
2. Height _____ ft. _____ in. 3. Weight _____ lbs.
- If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. Yes No
☐ ☐

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section.
Include provider, date, symptoms, diagnosis and treatment.

Yes No

Remarks - Explain All Yes Answers
Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? ☐ ☐
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? ☐ ☐
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? ☐ ☐

☐ ☐

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you ever:			
a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Attended or joined any organization due to alcohol or related problems?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the past 2 years ?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, list in Remarks section at right.			
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, give details. _____			
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

Signature of Proposed Insured

Signed at _____ on ____/____/____
City/State Date

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured_____
Date of this TIAA_____
Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent_____
Licensed Insurance Agent Number

**TEMPORARY INSURANCE APPLICATION
AND AGREEMENT (TIAA)**

Name of Proposed Insured _____ Date of Birth _____

Notice to Proposed Insured and Owner. Payment of the Amount Remitted may only be made at the same time that both the Application - Part 1 and this TIAA are completed. If the Insurer does not respond to you within 90 days, notify the Insurer at the above address. **Make the Amount Remitted payable to Banner Life Insurance Company. Do not make it payable to the licensed insurance agent or leave the payee blank. We do not accept cash or cash equivalents (money orders, cashiers checks) or "starter" checks.**

TEMPORARY INSURANCE APPLICATION (Answer all questions.)

Insurer The Insurer is Banner Life Insurance Company.

Temporary insurance cannot begin and you should make no payment if any question below is answered "Yes" or left blank.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the Proposed Insured less than 15 days old or more than 70 years old (age nearest birthday) on the date of this TIAA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the total amount of insurance on the Proposed Insured's life now applied for or pending with Banner Life Insurance Company exceed \$1,000,000? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 90 days, has the Proposed Insured been admitted, or medically advised by a member of the medical profession to be admitted, to a hospital or other licensed health care facility, had surgery performed or recommended, or been medically advised to have any diagnostic test (excluding an AIDS-related test) that was not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. In the past 5 years, has the Proposed Insured been diagnosed, treated for, or been advised to be treated for: heart disease; stroke; cancer; alcohol or drug dependence or abuse; or insulin dependent diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED AMOUNT OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW.

TEMPORARY INSURANCE AGREEMENT

Agreement. Subject to the terms of the policy applied for and this TIAA, the Insurer agrees to pay the Limited Amount to the beneficiaries listed in the Application - Part 1 upon receipt of due proof that the Proposed Insured died, except due to suicide, and provided all eligibility requirements and conditions for coverage under this Agreement have been met. The consideration for temporary insurance is the Temporary Insurance Application and payment of an amount equal to the first modal premium for the plan applied for or completion of the payment options form.

Limited Amount. The Limited Amount is the lesser of: (1) the amount of insurance applied for in the Application or (2) \$1,000,000 minus the amount of insurance on the Proposed Insured's life with the Insurer under any other applications for insurance now pending or other temporary insurance agreements.

Start Date. Temporary insurance equal to the Limited Amount will begin on the Start Date subject to the terms of this TIAA. The Start Date is the Date of this TIAA.

Stop Date. Temporary insurance automatically ends on the **earliest** of the following: (1) the date the Owner withdraws the application for insurance or refuses to accept any policy issued or offered; (2) the date the Insurer mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Insurer; (3) the date the Insurer mails or otherwise provides notice to the Owner or his/her representative that it has declined or cancelled the application; (4) the date the Insurer mails or otherwise provides a premium refund to the Owner or his/her representative; (5) the date the policy is delivered to the Owner and delivery requirements have been completed.

Policy Date. The policy date of any policy issued will be the Start Date unless the policy is backdated at the Owner's request. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued.

Other Limitations. The Insurer's liability will be limited to a return of the Amount Remitted if: (1) any part of the life insurance application or this TIAA contains a misrepresentation material to the Insurer; or (2) the Proposed Insured dies by suicide.

TEMPORARY INSURANCE APPLICATION AND AGREEMENT (TIAA)

(continued)

I represent that: (1) I have read and received a copy of this TIAA and agree to all of its terms and conditions; (2) I understand and agree that temporary insurance will not begin if any question in this TIAA is answered Yes or left blank and any collection of premium will not activate coverage under this agreement; (3) the answers given in this TIAA are true and correct, and I understand that, if they are false, temporary insurance may be denied or declined; (4) I understand that completing this TIAA does not guarantee that the Insurer will issue a policy on the Proposed Insured's life; (5) I understand that the licensed insurance agent is not authorized to change or waive the terms of this TIAA or to collect premium if the Proposed Insured is ineligible for coverage under this Agreement; and (6) I understand that any premium submitted with this TIAA will be refunded if the Insurer does not approve the requested coverage.

Signature of Proposed Insured_____
Date of this TIAA_____
Signature of Owner (if other than Proposed Insured)

LICENSED INSURANCE AGENT'S STATEMENT

Amount Remitted \$ _____ Person from Whom Received _____

On the Date of this TIAA, I received the Amount Remitted in exchange for this TIAA. The TIAA bears the same date as the Application - Part 1. I agree that I am not authorized to change or waive the terms of this TIAA and represent that I have not attempted to do so. I have read and explained the terms of this TIAA to the Proposed Insured and Owner. I have left a copy with the Owner.

Signature of Licensed Insurance Agent_____
Licensed Insurance Agent Number

AGENT'S REPORT

1. Name of Proposed Insured _____ Date of Birth _____
2. Number of years you have known the primary Proposed Insured _____
3. Who first suggested the purchase of this insurance? ☐ Agent ☐ Owner/Applicant ☐ Proposed Insured ☐ Other _____
- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Was the application signed after all questions were answered?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you personally see the Proposed Insured?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did anyone sign or assist in the completion of Part 1 or Part 2 of the Application for or on behalf of the Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you aware of any information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability?...
If Yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did you provide the client with the Temporary Life Insurance Application and Agreement (TIAA) form?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Premium Class Quoted _____ | | |
| 10. Are there any personal or business companion applications?.....
If Yes, please provide name and date of birth in the Remarks section below. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. a. To the best of your knowledge, does the policy applied for involve the replacement of existing insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If Yes, has the Proposed Insured replaced other life insurance policies in the past 2 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are there any plans to sell or assign this policy to another person or entity, life settlement provider or investor, or will it replace a policy that has already been sold to a life settlement company or investor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Will the premium for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, please identify all parties involved and provide copies of all financing agreements or promissory notes and all related side agreements and schedules. | | |

Remarks _____

_____**STATEMENTS BY AGENT****I certify that:**

- I asked and carefully explained each question to the Proposed Insured and Owner/applicant before recording each answer prior to the application being signed;
- The answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief;
- The Proposed Insured and applicant know that any fraudulent statement or material misrepresentation in the application may result in loss of coverage under the policy;
- I have given the Notice to Proposed Insured attached to this application to the Proposed Insured;
- If the insurance applied for will or may replace any existing life insurance policy or annuity contract, I have completed any and all proper state required replacement form(s);
- I have explained to the Proposed Insured that if money is submitted with this application, conditions of the Temporary Insurance Application and Agreement must be met.
- If I become aware of a change in the health or habits of the Proposed Insured occurring after the date of the application but before the policy is delivered, I promise to inform the Company of the change and agree to withhold delivery of the policy until instructed by the Company to do so.

Signature of Licensed Insurance Agent _____	Date _____	Phone No. () _____
Print Name of Above Signature _____		Agent # _____ SSN _____
Print Name of Agency, if different from above _____		Share of commission _____
Signature of Additional Licensed Insurance Agent _____	Date _____	Phone No. () _____
Print Name for Above Additional Signature _____		Agent # _____ SSN _____
Print Name of Additional Agency, if different from above _____		Share of commission _____

GENERAL AGENT INFORMATION

GA name _____ GA # _____ Case Manager _____

1. Name of Proposed Insured _____ Date of Birth _____
2. Height _____ ft. _____ in. 3. Weight _____ lbs.
- If your weight has changed by over 10 lbs. in the last year, indicate amount and reason _____

PHYSICIAN INFORMATION

4. **Primary Physician**

Name _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

5. **Physician Last Consulted**

Name _____ Specialty _____

Address _____

Telephone _____ Date last seen _____

Reason last seen and results of visit _____

6. Has a parent or sibling ever been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide or Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Family History chart below. ☐ Yes ☐ No

Family History: Include the age at onset/event for each medical condition.

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Brothers					
Sisters					

MEDICAL HISTORY - Provide details to Yes answers in the Remarks section. Include provider, date, symptoms, diagnosis and treatment.

Remarks - Explain All Yes Answers
Enter question number before detailed response.

Questions 7-22, have you ever consulted a member of the medical profession regarding or have you been diagnosed or treated for:

7. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☐ No
8. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum? ☐ Yes ☐ No
9. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)? ☐ Yes ☐ No

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
10. Cancer, tumor, melanoma, or any other malignant disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
11. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Any disease or disorder of the prostate or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Any sexually transmitted disorders or diseases?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17. Pregnancy, complications of pregnancy or infertility?	<input type="checkbox"/>	<input type="checkbox"/>	
If now pregnant, what is the expected date of delivery? _____			
18. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
19. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
20. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	
21. Arthritis or disorder of the bones, skin or muscles?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Any disease or disorder of the eyes, ears, nose or throat?.....	<input type="checkbox"/>	<input type="checkbox"/>	
23. In the last 5 years , unless previously stated on this application, have you:			
a. Been treated by a member of the medical profession or at a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	
e. Been referred to any other member of the medical profession or medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Been unable to work, attend school or perform the normal activities of like age and gender, or been confined at home?	<input type="checkbox"/>	<input type="checkbox"/>	
24. a. Have you ever used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, please provide dates of use: From _____ To _____			
Name of drug used: _____			
Amount and frequency of use: _____			

PART 2 - Medical History (continued)

Name of Proposed Insured _____	Yes	No	Remarks - Explain All Yes Answers
24 b. Have you ever been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?..... If Yes, provide dates of use, type and frequency.	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you ever:			
a. Consumed alcoholic beverages?..... If Yes, give type and number of drinks per day and/or per week. Date of last consumption: _____	<input type="checkbox"/>	<input type="checkbox"/>	
b. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Attended or joined any organization due to alcohol or related problems?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you currently:			
a. Taking or have you been advised to take any prescribed medication (other than contraceptives)?.....	<input type="checkbox"/>	<input type="checkbox"/>	
b. Taking any herbal or non-prescription medication at least weekly?..... If Yes, give details. _____	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you taken any other medications in the past 2 years ?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, list in Remarks section at right.			
28. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Auto Immune Deficiency Syndrome) caused by HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	
29. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, give details. _____			
30. Additional remarks (please indicate which question number remarks reference)			

I have read the answers as written before signing, the answers are true and complete to the best of my knowledge and belief, and there are no exceptions to any answers other than written on this document.

Signature of Proposed Insured

Signed at _____ on ____/____/____
City/State Date

Name of Proposed Insured _____ Date of Birth _____

Instructions to the Examiner -

This examination, once begun, is the property of the Company, and must not be destroyed or suppressed. Please weigh and measure this applicant. Explain all positive findings under Remarks.

The questions which appear below are intended only as a basis for the examination. The Company relies on its examiners to observe and report all information bearing on the acceptance of a proposed insured, even though not specifically requested on this form.

Please mail blood and urine specimens promptly.

- | | | | | | | | | | | | | | |
|--|---|----------|--|--|--|-----------|--|--|--|--|--|--|--|
| 1. Height (in shoes) _____ ft. _____ in.
Weight (clothed) _____ lbs.

a. Did you weigh? Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Did you measure? Yes <input type="checkbox"/> No <input type="checkbox"/>
If No, please explain _____

2. Measurements (males only)
Chest (full inspiration) _____ in.
Chest (forced expiration) _____ in.
Abdomen (at umbilicus) _____ in. | 3. Blood Pressure (record 3 readings)
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Systolic</td> <td style="width: 50px;"></td> <td style="width: 50px;"></td> <td style="width: 50px;"></td> </tr> <tr> <td style="padding: 2px;">Diastolic</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;"></td> <td></td> <td></td> <td></td> </tr> </table>
4. Pulse At rest _____
Describe any irregularities (number per minute, etc.)

5. Are blood and urine specimens being collected
and mailed to the lab? Yes <input type="checkbox"/> No <input type="checkbox"/> | Systolic | | | | Diastolic | | | | | | | |
| Systolic | | | | | | | | | | | | | |
| Diastolic | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

IF EXAMINATION IS DONE BY A PHYSICIAN, ANSWER SECTIONS 6 AND 7. OTHERWISE GO DIRECTLY TO SECTION 8.

6. After physical examination and inquiry, do you find any abnormality of the following:

	Yes	No	Remarks
a. Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Skin (including scars), thyroid, lymph nodes, veins, peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Brain, nervous system (including reflexes, gait, speech, coordination, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Stomach, abdominal organs?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Is the liver enlarged or tender?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Musculoskeletal system (including spine, joints, amputations and deformities)?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Heart or blood vessels? (If there is a history of rheumatic fever, heart murmur, or if you find any abnormality in heart size, rhythm, or sounds, complete question 7.)	<input type="checkbox"/>	<input type="checkbox"/>	

Name of Proposed Insured _____

PART 3 - Medical Examiner's Report (continued)

7. To be completed if number 6.i. is answered Yes or if requested:			
	Yes	No	Remarks
a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Are there gallops (S3 or S4)?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Is/are there ejection sound(s) or systolic click(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Is/are there murmur(s) present? If Yes, fully describe under Remarks including timing (systolic or diastolic), intensity (grade 1-6), location, transmission, or radiation.	<input type="checkbox"/>	<input type="checkbox"/>	
8. a. Are you aware of additional medical history: signs, symptoms, or laboratory findings not brought out in the foregoing questions which may have a bearing on this risk?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Does the Proposed Insured appear in any way unhealthy or older than the stated age?	<input type="checkbox"/>	<input type="checkbox"/>	
9. a. Were you acquainted with the Proposed Insured prior to this examination?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, fully describe the relationship in Remarks.			
b. Are you the Proposed Insured's personal physician?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Was the examination conducted in a language other than English?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, indicate language used and provide name, address and relationship to Proposed Insured of person acting as interpreter.			
d. Did anyone sign or assist in the completion of the Part 2 Medical History for or on behalf of the Proposed Insured?	<input type="checkbox"/>	<input type="checkbox"/>	
10. How did you identify the Proposed Insured? <input type="checkbox"/> Driver's license <input type="checkbox"/> Other _____			
Record any additional medical information below. Use a separate piece of paper if necessary. Any additional comments regarding habits, character, residence, history or physical condition which may have a bearing on the risk will be appreciated. This information will be considered strictly confidential.			

I hereby certify that I have personally examined _____ and have correctly and fully reported my findings.

Name of Proposed Insured

Examined at _____,
Street address, City and State

this _____ day of _____, 20____ at _____ AM/PM.

Print Examiner's name _____

Signature of Examiner _____

☐ Paramed ☐ MD ☐ D.O.

Paramed Company _____

Telephone number _____

Address _____

POLICY SCHEDULE

<u>FORM NUMBER</u>	<u>TYPE OF COVERAGE</u>	<u>EXPIRATION DATE</u>	<u>FACE AMOUNT</u>	<u>*ANNUAL PREMIUM</u>	<u>RATING CLASSIFICATION</u>
RT-97	RENEWABLE AND CONVERTIBLE TERM	08/13/2048	\$250.000	\$1,157.50	PREFERRED NONTOBACCO
	POLICY FEE			\$ 65.00	
AIR (1-11)	ADDITIONAL INSURANCE RIDER (10 YEAR TERM)	08/13/2021	\$100,000	\$282.00	PREFERRED NONTOBACCO
	RIDER POLICY FEE			<u>\$ 25.00</u>	
TOTAL				1,529.50	

MAXIMUM ANNUAL PREMIUM: YEARS 1 \$1,529.50
YEARS 2+: SEE SCHEDULE PAGE 3A

*PREMIUMS MAY BE CHANGED AS PROVIDED IN THE CHANGE OF PREMIUM PROVISION, BUT THE ANNUAL PREMIUM WILL NOT EXCEED THE MAXIMUM ANNUAL PREMIUM SHOWN. ADDITIONAL ANNUAL RENEWAL PREMIUM FOR RIDERS ARE SHOWN ON PAGE 3B.

PREMIUM MODE: QUARTERLY
PREMIUM DUE DATE: 8/13

*PREMIUM MODES AVAILABLE:	ANNUAL \$1,529.50	SEMI-ANNUAL \$780.05	QUARTERLY \$397.67	PAC \$139.34
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END OF CONVERSION PERIOD: 08/12/2023

END OF EXCHANGE PERIOD: 08/12/2023

ADDITIONAL INSURANCE RIDER (10 YEAR TERM):
END OF CONVERSION PERIOD: 08/12/2021

INSURED: JOHN DOE
ISSUE AGE AND SEX: 58 MALE
OWNER: JOHN DOE

TERM PERIOD: 20 YEARS
FOLLOW BY ONE YEAR PERIODS
ISSUE DATE: 09/08/2011
POLICY DATE: 08/13/2011
POLICY NUMBER: 0100000000



POLICY SCHEDULE (CONTINUED)

<u>YEAR</u>	<u>MAXIMUM ANNUAL RENEWAL PREMIUM</u>	<u>YEAR</u>	<u>MAXIMUM ANNUAL RENEWAL PREMIUM</u>
2	1,222.50	20	1,222.50
3	1,222.50	21	48,127.50
4	1,222.50	22	53,640.00
5	1,222.50	23	59,780.00
6	1,222.50	24	66,702.50
7	1,222.50	25	74,610.00
8	1,222.50	26	83,622.00
9	1,222.50	27	93,640.00
10	1,222.50	28	104,505.00
11	1,222.50	29	116,060.00
12	1,222.50	30	128,237.50
13	1,222.50	31	140,847.50
14	1,222.50	32	154,032.50
15	1,222.50	33	167,960.00
16	1,222.50	34	182,840.00
17	1,222.50	35	199,105.00
18	1,222.50	36	217,370.00
19	1,222.50	37	240,280.00

ABOVE PREMIUMS REFLECT POLICY FEES SHOWN ON PAGE 3. RIDER PREMIUMS ARE SHOWN SEPARATELY IF APPLICABLE ON PAGE 3B.

POLICY SCHEDULE (CONTINUED)

ADDITIONAL INSURANCE RIDER - 10 Year Term

<u>YEAR</u>	<u>ANNUAL PREMIUM</u>	<u>ADDITIONAL INSURANCE AMOUNT</u>
2	307.00	100,000
3	307.00	100,000
4	307.00	100,000
5	307.00	100,000
6	307.00	100,000
7	307.00	100,000
8	307.00	100,000
9	307.00	100,000
10	307.00	100,000

ABOVE PREMIUMS REFLECT RIDER POLICY FEES SHOWN ON PAGE 3.